II. Guidelines for Completing the SCDDSN Service Coordination Annual Assessment (Updated 04/03/2009)

Overview

The *SCDDSN Service Coordination Assessment* was developed to thoroughly assess a person's needs in preparation for the development of the *Support Plan*. It is solely the Service Coordinator's responsibility to complete the assessment. Service Coordinators will be constantly collecting information to complete the assessment but should begin specific efforts toward completion approximately 90 days prior (when completing the third quarter monitoring of the Plan) to the expiration of the Plan. The SCDDSN Service Coordination Annual Assessment must be completed in its entirety before the Support Plan is developed and completed.

The SCDDSN Service Coordination Assessment will be completed/generated using the Consumer Assessment and Planning (CAP) module of the SCDDSN Consumer Data Support System (CDSS). The assessment information/data must be entered into the CAP module of CDSS before a Support Plan can be developed. After information is entered into the assessment, the CAP module will automatically identify needs as programmed from the information keyed into the assessment, will provide a summary of the identified needs, and will develop a worksheet to assist in prioritizing needs for the plan. The CAP module requires that all parts of the assessment are addressed before a completed assessment is produced and before moving to the next component of planning the system. Also, the assessment worksheet (the next component of planning in the CAP module) must be completed before plan development occurs.

Gathering Information

The information to complete the assessment should be obtained by talking to the person, his/her legal guardian; others actively involved in his/her life (e.g. family, friends, service providers, etc.), reviewing current reports of progress/status, and reviewing any other service assessments or reports that pertain to the person. When the person receives services such as attendant care, personal care, day habilitation, supported employment, residential habilitation, nursing, etc., information from the staff (direct support/care) who provides the actual service should be sought. Face-to-face meetings with direct service providers are not required; however, such interviews likely will produce information about the person that would otherwise not be known or considered. Direct service providers are typically more knowledgeable of the day-to-day routines, feelings, preferences, and desires of the person they support. They typically form close relationships and have the most accurate information and greatest insight about the strengths, abilities, needs, and desires of the person.

Analysis of Information

Once as much information as possible concerning all aspects of the person's life has been gathered, the information should be synthesized. To synthesize means to combine, often of diverse conceptions, into a whole. Therefore, Service Coordinators must consider all of the information gathered and, as a professional, make a judgment as to the most

accurate response to each assessment question. The responses to items/questions on the assessment are to be the professional opinion of the Service Coordinator and must be based on the information gathered and considered. The assessment should not necessarily reflect the direct responses or desires of the person/guardian/family; responses should be based on all information gathered (inclusive of the person/guardian/ family) and must reflect the demonstrated need as determined by the Service Coordinator after all information has been considered from all possible sources. For example, a family member may report that the person has seizures. However, there is no medical evidence to support this assertion even after neurological evaluations have been completed and no interventions have been prescribed. As another example, the family may express a need for respite services for 4 hours daily. The information gathered indicates that the sixteen year old person receiving services is capable of completing his own personal care and ADLS (Activities of Daily Living Skills), attends public school, and lives with his mother and adult sister, both of whom do not work outside of the home.

Completing the Assessment

This assessment should <u>never</u> be used as a questionnaire to be answered by the person/guardian/family or other professional. The Service Coordinator will want to gather information from all sources and then complete the assessment on the CAP module of CDSS. A response should be given/entered for each question on the assessment. There is a "Comments" box at the end of each section or domain of the assessment that can be used, as needed, to explain the responses and/or any discrepancies in responses each question/item on the assessment.

The keyed response to each question/item on the assessment will lead to an identification of the person's needs (in most instances, the shaded responses indicates an area of concern or need as seen on the printed assessment form from the CAP module). Once keyed into CDSS, the assessment is complete.

During planning, a decision will be made regarding each need. Each will either be formally addressed (included in the *Support Plan*) or not. . A summary of identified needs is available on CDSS and can be printed to assist with planning. The Consumer Assessment and Planning module on CDSS also includes a "Worksheet" that will assist in prioritizing needs to be addressed on the Support Plan (*Assessment Summary/Planning)*. At least one identified need will be on the Support Plan for each domain/section of the assessment unless an explanation is documented in the Worksheet section of CAP module as to why none of the identified needs are being addressed.

Intent and General Instructions

A. <u>Identifying Information</u>

"Assessment Completion Date" means the date the assessment document is finalized (all sections are complete and needs are generated in the Worksheet section of the CAP module*)*. The "Next Plan Due Date" means the date by which the upcoming

Plan (for which the assessment is being completed) must be completed. The CDSS will automatically generate this date as the assessment is keyed.

B. Sources of Information

The Sources of Information section of the assessment is composed of two parts:

I. *People Providing Input*

The name/relationship of every person who provides information for the purpose of completing the assessment should be keyed here. Only those contacts or interviews that result in information being provided for the assessment should be used. Sources of information should include, but are not limited to, the person, his/her legal guardian and/or family, and those actively involved in the person's life (direct support providers, friends, etc.).

II. *Records/Reports Used:*

Every record or report from which information is obtained for the purpose of completing the assessment should keyed. Enter the title of the reports or information that can be used to identify the report/ record, the author (person or agency), and date of the report. Reports used should be those that give information that directly impacts current services/supports. Most information should be current within the past two years. However, there may be other older reports, such as psychological evaluations, that may be important. Only those records/reports that are reviewed and where provided information is used for the assessment should be included. Attempts to obtain information, records, and/or reports should not be entered nor is it necessary to enter reports that were reviewed but were not useful.

C. Health

The intent of this section is to gain an overall understanding of the person's health in order to identify any health needs.

"Primary Care Physician" may also be called "family doctor". Having a primary care physician helps maintain continuity with the health care that is provided. People without a Primary Care Physician should be encouraged to find one. **NOTE**: The name of the Primary Care Physician should be recorded elsewhere in the record.

"Regular" visits to the Primary Care Physician mean that the person is seen routinely enough to assure that his/her health is being monitored/maintained. There is no expectation that a specific regularity of visits be maintained. "Regular" dental visits means that visits are sufficient enough to assure oral health. There is no specific schedule to be met. Genetic Services/Counseling – those services provided by Greenwood Genetic Clinic for individuals and families who have developmental delay, mental retardation, learning disabilities, autism and birth defects. The purpose of these services may be helpful to determine if certain treatments or specialist can benefit the genetic condition. Also, these services can help the person and/or their

family deal with emotional issues related to the disability and can identify support services they may need. Genetic services may also help to explain the chances for a certain disability to be passed on and what testing is available for other family members.

Indicate if a health professional prescribed or recommended a diet for this person. This should not reflect self-imposed diets including Weight Watchers, etc. However, if weight appears well outside of normal limits, a concern should be noted.

Information about health guidelines and screenings means information about the importance of health screenings/assessment (annual physical, obstetrics/gynecological exams, mammogram, etc.) and the suggested frequency.

The chart in this section should list the medical condition, intervention/treatment/supplies used as a result of the condition (if any), and the provider type that is providing the intervention/treatment/supplies. Provider type is the kind of provider who will provide the service; NOT the actual name of the provider. Provider type relates to the service name. **For Waiver participants, refer to the appropriate HCB Waiver Manual for the appropriate provider type for each waiver-funded service.**

Some examples are, but not limited to, the following:

1. Respite services can be provided in a licensed respite setting by a licensed respite provider.
2. Personal care services (PCA) are provided by personal care providers or Medicaid enrolled PCA providers.
3. Specialized supplies, medical equipment and assistive technology are provided by a durable medical equipment provider.

The chart also asks if the intervention/treatment/supplies are used or taken as prescribed, the current funding source that pays for the intervention/treatment/supplies, and whether the intervention/treatment/supplies are effective in meeting the need for which it is being given.

Indicate the type of disability in this section, question 8. Explain/list, if applicable, what the "Related Disability", "Level of Spinal Cord Injury", "Similar Disability", or "Other" is. Also, if the person has a Brain Injury, indicate whether the person has an "Open" or "Closed" injury.

D. <u>Current Resources:</u>

The intent of this section is to obtain information regarding all financial resources (available to the person in to determine if those resources are adequate to meet basic needs (food, clothing, shelter) and special needs related to his/her disability.

Definitions of Resources:

- <u>Earned Income</u>: Compensation from participation in a business, including wages, salary, tips, commissions and bonuses.

- SSDI (Social Security Disability Insurance): A cash benefit provided to disabled or blind people who are "insured" by workers' contributions to the Social Security trust fund. These contributions are the Federal Insurance Contributions Act (FICA) social security tax paid on their earnings or those of their spouses or parents.
- SSI (Supplemental Security Income): Cash assistance payments to aged, blind, and disabled people (including children under age 18) who have limited income and resources.
- VA Pension/Compensation (Veterans Affairs Pension/Compensation): Disability compensation is a monetary benefit paid to veterans who are disabled by injury or disease incurred or aggravated during active military service. Veterans with low incomes who are permanently and totally disabled may be eligible for monetary support through VA's pension program. Benefits may also be received by spouses, children and parents of deceased veterans.
- Disability Insurance: Disability insurance is insurance that can replace a portion of income when you a person is unable to work because of injury or illness. There are two major types of disability coverage: short term and long term. Short term disability provides an income for the early part of a disability. Long term disability helps replace income for an extended period of time, usually ending after five years or when the disabled person turns 65.
- Workers' Compensation: Workers' Compensation in South Carolina is a system created and regulated by State law which requires most employers to obtain insurance or to be responsibly self-insured for purposes of providing benefits to employees injured at work. Benefits may include payment of medical bills, lost wages, and awards for permanent disability and scarring. (Workers' Compensation also covers treatment for occupational diseases if caused by conditions of employment). Dependants of employees who die as a result of work-related accidents or occupational diseases may be eligible for benefits.
- Food Stamps: The Food Stamp Program enables low-income families to buy nutritious food with coupons and Electronic Benefits Transfer (EBT) card in authorized retail food stores.
- Housing Supplement: A benefit to assist low-income people/families in having the opportunity to live in safe, decent, and affordable housing. Refer to the State Housing Authority website to find specific information on the program/supplements available to South Carolinians (www.sha.sc.gov)
- Child Support: A cash payment made by the non-custodial parent to the custodial parent (who has physical custody) of a child for the purpose of assisting in supporting the financial needs of the child.
- Trust: A trust is a means by which an individual transfers legal ownership of funds to a trustee with the intention that the funds will be used by the trustee for the benefit of a designated person.
- Health Insurance: Private health insurance is coverage by a health plan provided through an employer or union or purchased by an individual from a private health insurance company.

- Alimony: A cash allowance for support made under court order to a divorced person by the former spouse, usually the chief provider during the marriage. Alimony may also be granted without a divorce, as between legally separated persons.
- Medicaid: Medicaid is health insurance administered at the State level that helps many people who can't afford medical care pay for some or all of their medical bills. Medicaid is available only to certain low-income individuals and families who fit into an eligibility group that is recognized by federal and state law. Medicaid does not pay money to people; instead, it sends payments directly to their health care providers.
- Medicare: A two part Federal health insurance program for eligible disabled people, people age 65 or older and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

  Medicare has:

  Part A- Hospital Insurance - Most people don't pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A (Hospital Insurance) helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits.

  Part B- Medical Insurance - Most people pay a monthly premium for Part B. Medicare Part B (Medical Insurance) helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

  Part C - Managed Care –Medicare + Choice (Part C) is an expanded set of options for the delivery of health care under Medicare, created in the Balanced Budget Act passed by Congress in 1997. The term Medicare + Choice refers to options other than original Medicare. While all Medicare beneficiaries can receive their benefits through the original fee-for-service (FFS) program, most beneficiaries enrolled in both Part A and Part B can choose to participate in a Medicare + Choice plan instead. Organizations that seek to contract as Medicare + Choice plans must meet specific organizational, financial, and other requirements. Most Medicare + Choice plans are coordinated care plans, which include health maintenance organizations (HMOs), provider-sponsored organizations (PSOs), preferred provider organizations (PPOs), and other certified coordinated care plans and entities that meet the standards set forth in the law. The Medicare + Choice program also includes Medical savings account (MSA) plans, which provide benefits after a single high deductible is met, and private, unrestricted FFS plans, which allow beneficiaries to select certain private providers. These programs are available in only a limited number of States. For those providers who agree to accept the plan's payment terms and conditions, this option does not place the providers at risk, nor does it vary payment rates based on utilization. Only the coordinated care plans are considered "managed care" plans. Except for MSA plans, all Medicare+Choice plans are required to provide at least the current Medicare benefit package,

excluding hospice services. Plans may offer additional covered services and are required to do so (or return excess payments) if plan costs are lower than the Medicare payments received by the plan.

Part D - Prescription Drug Coverage - Most people will pay a monthly premium for this coverage. The Medicare prescription drug coverage is available to everyone with Medicare. Everyone with Medicare can get this coverage that may help lower prescription drug costs and help protect against higher costs in the future. Medicare Prescription Drug Coverage is insurance. Private companies provide the coverage. Beneficiaries choose the drug plan and pay a monthly premium. Like other insurance, if a beneficiary decides not to enroll in a drug plan when they are first eligible, they may pay a penalty if they choose to join later.

- Retirement/Pension: Cash which a retired person now receives from an account where they had set aside income up to a specified amount each year while working in order to support them after retirement.
- HCBS Waiver (Home and Community-Based Services Waiver): The Medicaid Home and Community-based Services Waiver program allows Medicaid to pay for long term care in the community as opposed to an institution. South Carolina currently has Home and Community Based Waivers for people with the following disabilities:
  - Mentally Retarded/Related Disabilities,
  - Head and Spinal Cord Injury,
  - Elderly and Disabled,
  - Ventilator Dependant, and
  - HIV/AIDS.
- Family Support Funds: Family Support Funds are cash payments or services to individuals/families to assist with the cost of caring for a DDSN eligible person. Family Support Funds are provided to those who are at risk for out-of home placement. This service is directed toward individuals and families who can care for themselves or their family member at home, but incur additional expenses due to the disability. This funding should be used for needs that are not incurred routinely by families with non-disabled individuals.
- PASS (Plan for Achieving Self-Support): A Plan that allows a person to set aside income and/or resources over a reasonable time which will enable them to reach a work goal to become financially self-supporting. The income and resources set aside can then be used to obtain occupational training or education, purchase occupational equipment, establish a business, etc. The income and resources set aside under a PASS is not used when deciding SSI eligibility and payment amount. Indicate if it appears that current resources are adequate to meet the person's basic needs. This is not a judgment of quality, only a judgment about the sufficiency of resources to meet basic needs.
- IRWE (Impairment-Related Work Expenses): A deduction of the cost of certain impairment-related items and services a person needs to work from their gross earnings. A deduction is made when the item or service enables a person to work, the person needs the item or service because of their disabling impairment, the cost of the item or service is not reimbursable by another source (i.e. Medicare, Medicaid, or private insurance), the cost of the item or service is reasonable (i.e. it represents the standard charge for the item

or service in the local community), and the person paid the expense in a month that they are or were working. Refer to www.socialsecurity.gov for further information pertaining to IRWE.

- Life Insurance/Burial Insurance: An insurance policy available upon death of the person to resolve expenses incurred by the person or needed to pay for burial expenses.

Check all resources that apply in this section of the assessment by clicking on those items.

E. Activities/Skills/Abilities

This section is designed to broadly ascertain which daily living skills and personal care skills the person can do and/or those for which supports are needed. For each activity, indicate the amount of assistance needed, how often the activity is expected to occur, the frequency with which support is provided and the type of support provided. If supports are provided, indicate the ability of each supporter to continue and whether training, instruction or intervention would likely be beneficial and desirable. If it is not expected to be both beneficial and desired by the person, score "no". Please Note: for some people, a support may be provided even though it is not needed (example: prepares meals with very little or no supervision but support provided three times daily by paid supporter). Situations such as this should be explained in the comments section at the end of the section. Check all appropriate answers for each question.

I. Daily Living Activities/Skills/Abilities

"Prepare meals" means prepare, not consume.

"Housekeeping" includes tasks necessary to keep the home safe and clean including laundry, mopping, sweeping, general cleaning, trash disposal, etc.

"Medical care/monitoring" are those skills of being able to take care of or arranging for the care of and monitoring of medical conditions. This would be arranging for doctors appointments, Home Health, basic first aid, treatment of colds or other common ailments; knowing when expert medical intervention is needed, etc.

"Shopping" includes knowing what is needed, where to obtain, how to make purchases, etc.

"Personal Finances" means being able to carry money to meet their financial obligations (such as paying bills, manage money, and purchase things they need or desire; pay income tax).

"Phone use" means making calls, receiving calls, phone etiquette, safety/calling 911 (not giving personal information to unknown callers), etc.

II. Personal Care Activities/Skills/Abilities

Respond as indicated.

Eating means consuming food, not preparation of meal or clean-up after meals.

"Taking or applying medication" means being able to remember when and how to take or apply medications as prescribed and being able to take/apply OTC medications appropriately.

"Transferring" means being able to physically move self into and out of wheelchair from other locations (i.e., bed, toilet, bathtub/shower, car, etc.).

"Supervise self" is to be able to be alone, or to be without the supervision of another, and do so without threat of danger. The age of the person must be considered. The expectation is that no supports are needed if the needed supervision is equivalent to that of someone of the same age who does not have a disability. If currently being supervised, this assessment must <u>not</u> automatically reflect the supervision provided. If an adult receives more supervision than appears to be needed, this should be noted and addressed. *Please note: For those enrolled in the MR/RD or HASCI Waiver under the ICF/MR Level of Care, section II of the Level of Care Determination should be consistent with this response.*

Provide information in this section (numbers 3- 6) about the person's abilities related to mobility and access, fine motor, communication and basic transportation including any equipment used to aid the person in these areas.

Note: For "Communication", question 5 in this section, truly not communicating is rare. Many people communicate without words through expressions, gestures, behavior. If the person does not use words, it is important to determine how he/she does communicate. If the person truly does not communicate (e.g., chronic vegetative state, persistent vegetative state) then note in the comments box at the end of this section.
Note: For "Basic Transportation", question 6a in this section, the availability of basic transportation implies that a vehicle is available.

Check all appropriate answers for each question.

F. <u>Emotional, Mental, Behavioral Health</u>:
In this section, the intent is to identify any behaviors, mental health or emotional issues that are a concern and the affect these issues have on the person's abilities so that consideration is a priority during planning. Behaviors or other issues that are historic (not occurring presently) may still be considered. For example, incidents of criminal behavior may not be occurring presently due to supervision; however, repeated historic incidents make this a concern that must be considered when planning. This section also includes any services or supports currently provided to address emotional, mental or behavioral health, whether the service/support is effective, and whether or not the person is satisfied with the service. *Please note: Responses in this section should correspond to responses in section II of the ICF/MR Level of Care if the ICF/MR Level of Care is completed.*

Choose appropriate answers for each question.

G. Educational Opportunities:
This section is intended to identify if the person is interested in an educational program or if attending school, the type of school and any concerns related to the person's current educational program.

Choose appropriate answers for each question.

H. Vocational:
This section is intended to identify the supports/services needed, if any, to enable the person to work or continue to work. "Competitive job" means working in a job making competitive wages; "sheltered work setting" means working for less than competitive wages with supports in settings like the Adult Activity Center, Enclave, Mobile Work Crew, DDSN Service Provider owned business (if not paid competitive wage).

Choose appropriate answers for each question.

I. Living Environment:
This section is intended to identify the person's current living situation, the supports/services provided in that setting, the status and stability of the situation and any related needs. Of particular importance is the assessment of how prepared the person is for emergencies, how likely it is that this situation will continue, and how satisfied the person is with the current situation.
Choose appropriate answers for each question.

J. Community Connections:
This section is intended to identify whether the person is present, participates, and/or has a role in their community.

"Present" = is the person ever in the community; do they accompany others to the store, bank, church, etc.

"Participates" = actually uses the community services first hand (makes own purchases, does own banking, etc.).

"Has a role" = holds some "position" in the community such as a regular customer/patron, church member, church usher or choir member. The person is considered to "have a role" when he/she is known in the community and his/her presence is expected.

Choose appropriate answers for each question.

K. Natural Support Network:
This section is intended to identify if the person has contact with family and/or friends, and if they are satisfied with the amount of contact they have. Having family and friends often provides one with a support network through which the person's welfare is "monitored" and

needs are met without a paid support. Family and friends may help the person with finding monitored paid solutions to concerns.
Choose appropriate answers for each question.

L. <u>Self-Advocacy and Rights</u>:
This section identifies whether the person expresses personal preferences and interests, makes their own choices, demonstrates problem-solving skills, advocates for themselves, whether adjudicated incompetent and who their legal guardian is, whether they know and exercise their civil and human rights, and whether the person feels they are treated fairly.

- Include information about basic civil and human rights.
- Provide information about considerations to be made when the person doesn't express preferences, exercise rights; give consent (consider DDSN Policy #535-07-DD, *Obtaining Consent For Minors and Adults*)

Choose appropriate answers for each question.

M. <u>Personal Priorities</u>:
This section will identify if the person has chosen goals for his/her life and if he/she has expressed an interest in obtaining assistance to achieve those goals.
Choose appropriate answers for each question.

CDSS Consumer Assessment and Planning Module "Worksheet"

When completed and an assessment completion date is entered, a summary of needs is automatically generated by CDSS based on entered/chosen responses to each question. The summary of needs can be printed and serve as a tool for planning. Those items on the assessment that are indicative of a need (those with shaded boxes and others as generated by CDSS and seen on the printed document) should be prioritized using the CDSS Consumer Assessment and Planning Module "Worksheet". Once needs are prioritized/grouped according to the service/intervention to address the need, the CDSS will generate a Support Plan. Every Waiver service will have a separate need on the plan; therefore, when completing the worksheet, make sure needs are not grouped together if provided when addressing needs.

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